No. 87-850

Supreme Court, U.S.
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In The Supreme Court of the United States

October Term, 1987

HART SCHAFFNER & MARX and HART SCHAFFNER & MARX SUBSIDIARY AND AFFILIATED COMPANIES GROUP LIFE INSURANCE AND MEDICAL PLAN,
Petitioners,

v.

BARBARA AND CHRISTOPHER SCHULTZ, individually and on behalf of their minor daughter, RACHAEL SCHULTZ,
Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITIONERS' REPLY TO OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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I

INTRODUCTION

The Question Presented; Parties to the Proceedings; Opinions Below; and Statements of Jurisdiction, of the Case and of subsidiary and affiliate relationships are fully set forth in Petitioners' Petition for a Writ of Certiorari.

II

ARGUMENT

Respondents' Opposition Brief addresses a number of the facts and issues which the parties disputed in the trial court, but offers little to establish that this Honorable Court should refuse to hear this matter. The District Court twice determined that Respondents' action was required to be dismissed for failure to exhaust administrative remedies, and the Opposition Brief seems intent to again raise, and impermissibly

reargue in these papers, contested facts or matters simply not germane.

The opposition to the granting of the Writ appears to be primarily grounded upon assertions that this cause presents only procedural or "insignificant" matters, not worthy of the attention of this Court. In doing so, the Opposition not only misrepresents the Plan's requirements respecting administrative review, but also overlooks the nature and import of the exhaustion doctrine itself.

For example, Respondents allude to a supposed ability of the Plan to somehow delay administrative review until after a prescriptive period ran. This assertion is utterly false. Section 7.4 of the Plan document specifies that:

> Within 10 days of receiving a request for review, the Named Fiduciary shall acknowledge in writing to the person

filing the request the receipt thereof and the date of such receipt. The Named Fiduciary shall then review the matter and, after such consultation with the Participant or Beneficiary and Insurer as the Named Fiduciary deems appropriate, shall render a decision to the Participant or Beneficiary, which decision shall be made not later than 60 days following receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days following receipt of the request for review. Except as may be otherwise required by law, the decision of the Named Fiduciary shall be binding on all parties. (emphasis added)

The Plan document is set forth in its entirety in the Appendix hereto.

Understandably, Respondents do not refer in Opposition to their actual acknowledge of the availability, nature and extent of administrative appeals procedures as early as December 1981, nor to their receipt of written direction thereto in 1984, nor to their determined refusal throughout 1985 and 1986 to seek such administrative review, preferring instead to litigate in the District Court in efforts to excuse such review.

It is precisely these kinds of litigation proceedings which are forbidden by the Fifth Circuit by its determination that claimants under ERISA plans are required to exhaust administrative remedies provided thereunder before filing suit on any denial of benefits claims: "To preserve the integrity of ERISA, we hold as a matter of law that the doctrine of exhaustion of

remedies is applicable to the denial of benefits by Plan Trustees." Denton v. First National Bank, 765 F.2d 1295, 1297 (5th Cir. 1985). It is stipulated that Respondents are claimants under an ERISA plan, and it is undisputed that administrative review was not sought until after the District Court litigation and, indeed, until after Respondents appealed the dismissal of their action in December 1986.

The Fifth Circuit's opinion, which allows the original cause to proceed, simply abrogates the exhaustion doctrine and the Fifth Circuit's own unequivocal determination that "we agree . . . that Congress, in enacting ERISA, clearly wanted potential plaintiffs to first exhaust their administrative remedies before resorting to the federal courts. Denton, 765 F.2d at 1303. If claimants may permissibly exhaust either before or after they litigate their federal

cause, the requirement of prior exhaustion is obviously disregarded. This is deemed "insignificant" in the Opposition.

The doctrine exists, at least in part, to prevent every ERISA action from literally turning into a federal case. Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980); Denton, 765 F.2d at 1300. Respondents have not, and cannot, offer any adequate justification for the suspension, if not abrogation, of the exhaustion doctrine, so recently adopted by the Fifth Circuit. To permit Respondents to exhaust after, not before, they prosecute their federal case upends both the rule and its sound policy reasons.

CONCLUSION

For the reasons stated above, we urge that the Petition for Writ of Certiorari be granted.

Respectfully submitted,

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APPENDIX

HART SCHAFFNER & MARX
SUBSIDIARY AND AFFILIATED COMPANIES
GROUP INSURANCE AND MEDICAL BENEFITS PLAN

SECTION I

INTRODUCTION

This Group Insurance and Medical Benefits Plan has been established by Hart Schaffner & Marx in order to provide life and liability insurance and medical benefits for eligible employees.

The effective date of the Plan was October 15, 1956. The Plan, as amended through March 1, 1976, is set forth below.

SECTION 2

DEFINITIONS

2.1 Definitions

The following words and phrases shall have the meanings stated below unless a different meaning is plainly required by the context:

1. "Plan" means the plan described in this instrument and known as "Hart

Schaffner & Marx, Subsidiary and Affiliated Companies Group Insurance and Medical Benefits Plan," as the same may, from time to time, be amended. "Company" means Hart Schaffner & Marx, a New York corporation.

2. "Subsidiary" means any United States corporation of which Hart Schaffner & Marx is the owner of more than 50% of the shares of its outstanding stock having voting rights.

3. "Affiliate" means any corporation of which a Subsidiary is the owner of more than 50% of the shares of its outstanding stock having voting rights.

4. "Employer" means the Company, in case the participant is employed by the Company; it means the

Subsidiary or Affiliate participating in the Plan by which the participant is employed, in all other cases.

5. "Board of Directors" means the Board of Directors of Hart Schaffner & Marx

6. "Employee" means any individual who is in the regular full-time service and employ of the Employer, working at least 1,000 hours per year, but the term "employee" shall not include a member of the Board of Directors of the Employer unless such member is also an officer or employee of the Employer, and shall not include a temporary, seasonal or part-time employee.

7. "Annual Earnings" means the aggregate amount of compensation, including overtime, paid to an

employee by the Employer during a calendar year.

8. "Participant" means an employee who has become a participant under the provisions of Section 4.

9. Use of the masculine pronoun shall be deemed to include the feminine unless the context clearly indicates the distinction.

SECTION 3

DESIGNATION OF FIDUCIARY: ADMINISTRATION

The Company is designated as the Named Fiduciary of the Plan in accordance with the pertinent provisions of the Employee Retirement Income Security Act of 1974. The Company shall be the Plan Administrator responsible for the general administration of the Plan and carrying out the provisions thereof. The Company shall have all such powers as may be necessary to carry out the provisions of the Plan and from time to time

establish rules and regulations for the administration of the Plan and the transaction of the Plan's business. An officer of the Company designated by the Chairman or President of the Company shall cause benefits to be paid to persons entitled thereto hereunder and shall maintain, or cause to be maintained, such records and accounts and shall from time to time deliver such reports to employees, participants and government agencies, as shall be required by law or as may otherwise be necessary to show the contributions made by each participant, the separate contributions made by the Company and each subsidiary and affiliate which shall have adopted the Plan.

SECTION 4

ELIGIBILITY

4.1 Life Insurance and Medical Benefits

Each Employee who is not a participant in some other non-government

life and medical plan, the cost of which is borne in full or in part by the Employer, unless he is included in a collective bargaining unit with which the Employer has bargained in good faith with respect to benefits for the Employee which are not covered by the Plan, shall be eligible to become a Participant on the first day of the month after having completed at least one month of continuous service as an Employee. He may also obtain medical benefits under the Plan for his spouse and his dependent children (each child age 18 or under, each child age 22 or under who is a full-time student at an accredited school, and each child of any age who is incapable of self-sustaining employment by

reason of mental retardation or physical handicap).

4.2 Disability Insurance

Each Employee who is not a participant in some other non-government income plan, the cost of which is borne in full or in part by the Employer, unless he is included in a collective bargaining unit with which the Employer has bargained in good faith with respect to benefits for the Employee which are not covered by the Plan, and whose annual earnings from the Employer are at the rate of Ten Thousand Dollars ($10,000) or more, shall be eligible to become a Participant in the disability insurance provisions of the Plan on the first day of the month coincidental with, or following the date of, employment or the

date his rate of annual earnings qualifies him for participation.

SECTION 5

EMPLOYEE CONTRIBUTIONS

A Participant shall make contributions determined by the Plan Administrator on a non-discriminatory basis for all Participants employed by the Employer.

A Participant's contributions shall be made by payroll deductions and no refund of contributions is obtainable as long as he remains a Participant.

A Participant who fails or refuses to make a contribution in any month in which he is eligible to so contribute may resume contributions by making written application on a form provided by the Employer for that purpose and such application shall be approved promptly if the Participant is eligible and his participation shall be effective

the first day of the month following approval of his application by the Employer.

SECTION 6

RIGHTS, DUTIES AND OBLIGATIONS OF INSURER

Any right, duty (including the duty to make payment of any Plan benefits) or obligation reserved to or imposed upon an Insurer under any insurance contract issued by it or other agreement between it and the Company in connection with the Plan is in no way preempted, increased or diminished by virtue of any provision of this Plan and shall remain the sole right, duty or obligation of that Insurer.

SECTION 7

FILING CLAIMS AND REVIEW OF DENIAL OF CLAIM

7.1 Filing of a Claim

Claims for the payment of any benefits provided by this Plan shall be filed in accordance with the insurance contract or other

document pertaining to the benefits in question.

7.2 Notification of Decision

If a claim is wholly or partially denied, notice of the decision shall be furnished to the claimant, within a reasonable period of time after receipt of the claim by the Plan, setting forth:

(a) The specific reason or reasons for the denial;

(b) Specific reference to pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary; and

(d) An explanation of the provisions of subsections 7.3 and 7.4 of this Plan.

If notice of the denial of a claim is not furnished, and the claim has not been granted within a reasonable time the claim shall be deemed denied for the purposes of proceeding to the review stage described in subsection 7.3.

7.3 Review Procedure

Following receipt of notice of denial of any claim for a benefit under the Plan, a Participant or Beneficiary (named in accordance with the provisions of any insurance contract or other pertinent document), or the authorized representative thereof, may review the documents underlying such claim and on which the denial was based.

Within sixty days following the date of notice of denial of a claim, a Participant or a Beneficiary or the authorized representative thereof, may, in writing, request a review of such denial by the Named Fiduciary, and may submit written issues and comments to it.

7.4 Decision on Review

Within 10 days of receiving a request for review, the Named Fiduciary shall acknowledge in writing to the person filing the request the receipt thereof and the date of such receipt. The Named Fiduciary shall then review the matter and, after such consultation with the Participant or Beneficiary and Insurer as the Named Fiduciary deems appropriate, shall render a decision to the Participant or

Beneficiary, which decision shall be made not later than 60 days following receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days following receipt of the request for review. Except as may be otherwise required by law, the decision of the Named Fiduciary shall be binding on all parties.

SECTION 8

AMENDMENT OR TERMINATION

8.1 Amendment

While the Company expects to continue the Plan, it must necessarily reserve and reserves the right to:

(a) Amend the Plan and, in conjunction with any issuing insurer, amend or replace any insurance contract or other document identified in Section 10, from time to time; and

(b) Revise Plan benefits from time to time under any insurance contract or other document identified in Section 10 or substituted for any such insurance contract or other document.

8.2 Termination

The Company may at any time terminate the Plan or any insurance contract or other document identified in Section 10, or substituted for any such insurance contract, or other document, subject to the

contractual rights of the insurer, if any.

Adopted as amended in the form herein and above set forth by Hart Schaffner & Marx, a New York corporation, as of March 1, 1976.

HART SCHAFFNER & MARX

By_____

Jerome S. Gore, President